Elko County School District

Central Administrative Office
Telephone: (775) 738-5196 • Fax: (775) 738-0808
P.O. Box 1012 • Elko, Nevada 89803

HIPAA-Compliant Authorization for Exchange of Health and Education Information

Student Name: ______________________________ Date of Birth ______________

Address: ______________________________ Phone ______________

I hereby authorize ______________________________

(Name of health care provider, agency or medical institution)

Address: ______________________________

Phone: ______________________ Fax: ______________________

and **Elko County School District** to exchange health and education information/records for the purpose(s) listed below:

- ☐ Educational evaluation and program planning
- ☐ Health assessment and planning to ensure safe health care services and treatment in school.
- ☐ Other: ______________________________

I consent to the release of the following health information:

- ☐ Current medical status
- ☐ Recommendations for school
- ☐ Current medications/treatments
- ☐ Other: ______________________________

Elko County School District contact

Name/Title: ______________________________

Address: ______________________________

Phone: ______________________ Fax: ______________________

The methods for exchange may include written records as well as verbal exchange of information.

I understand that the released information becomes a part of the student's educational records and, as such, is protected by the Family Educational Rights and Privacy Act (FERPA). The information may only be reviewed by school staff identified as having legitimate educational interest. The information may also be used in the future for purpose of Individualized Education Program (IEP) decision making.

I understand that I have the following **rights** with respect to this authorization:

- The right to inspect or copy the health information to be disclosed by this form.
- The right to receive a copy of this form.
- The right to withdraw this authorization by written notification at any time (although my withdrawal will not be effective as to uses and/or disclosures already made regarding this form).

This authorization is valid until ____/____/____ , or until one year after the date of signing, whichever occurs first.

______________________________ ____/____/____

Signature *Relationship to Student* *Date*

____

Printed Name

______________________________ ____/____/____

*Signature of Student** *Date*

**If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form.*

Health Insurance Portability and Accountability Act (HIPAA)/ Family Educational Rights and Privacy Act (FERPA) Notice

Any and all personally identifiable information regarding children and families receiving Special Education services funded under the Individuals with Disabilities Education Act is protected from unauthorized disclosure under FERPA. Personally identifiable information protected by FERPA is specifically **exempted** from HIPAA privacy standards. FERPA prohibits disclosure of personally identifiable information without parent consent except in limited circumstances, requires notice to be provided to the child's family regarding their privacy rights, requires providers to keep records of access to a child's records, and contains complaint and appeal procedures which apply to disputes over records in possession of Special Education or its providers, among other provisions.